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The Concept of the Second Generation Program in the Treatment of Post-Traumatic Stress Disorder Among Vietnam Veterans

David Read Johnson,[1] Susan C. Feldman,[1] Steven M. Southwick,[1] and Dennis S. Charney[1]

The concepts of First and Second Generation treatment programs for Vietnam veterans with post-traumatic stress disorder are presented, based on a developmental theoretical model of adaptation. First Generation programs focus on accessing and then working through the effects of the war trauma and aim to diminish the intensity of core PTSD symptoms. Second Generation programs focus on reintegrating veterans into the social context of family and work, and aim to improve their ability to function in society. Both types of treatment may be required in order to help veterans resume their psychological and social development. The need to develop sophisticated models of comprehensive inpatient treatment in order to support scholarly discourse and outcome research is emphasized.

KEY WORDS: PTSD; Vietnam veterans; inpatient treatment; developmental theory.

INTRODUCTION

This paper will attempt to articulate the concept of a second generation PTSD program for Vietnam veterans. The war is now 20 years past, and many of the treatments currently being offered, particularly in inpatient programs, are based largely on principles of trauma treatment appropriate for newly traumatized persons. These treatments may not reflect the needs of veterans whose traumatic experiences have now

[1]National Center for PTSD, Veterans Affairs Medical Center, West Haven, Connecticut; and Department of Psychiatry, Yale University School of Medicine, New Haven, Connecticut 06516.

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transformed into a broad network of autonomous chronic conditions (Long *et al.*, 1989; Walker and Cavenar, 1982). The major treatment methods of abreaction, group support, and sanctuary may no longer be the most effective interventions.

Despite the continued interest in the etiology and dynamics of core PTSD symptoms (reexperiencing, avoidance, and hyperarousal), these constitute a relatively small portion of the treatment challenge. The disturbance caused by PTSD symptoms has spread out to ever wider areas of the person's cognitive, physical, behavioral, and social life. At the core are the PTSD symptoms created by the trauma. The second level consists of a number of associated psychiatric disorders involving anxiety, dissociative, impulsive or depressive symptoms. In attempting to deal with these symptoms, many veterans then turned to substance abuse. Collectively, these conditions then led to work dysfunction and legal problems. These problems increasingly strained their social networks, and resulted in divorce, loss of friendships, and eventually the loss of financial and material resources. In the final stage, the veterans succumb to a state of profound demoralization and hopelessness, not dissimilar to that in other untreated chronic mental conditions.

The progress of this disorder is aided by the veterans' ineffective coping strategies (such as isolation and substance abuse), and by the absence of appropriate treatment. Significantly, each of these problems develops into an autonomous, self-sustaining system, so that removal or diminution of the symptoms in one area may only partially influence symptoms in the other areas. In addition, attempts to treat one area may exacerbate stresses in other sectors (e.g., after a group on traumatic memories, a Vietnam veteran left the unit and got drunk; after a tense but successful couples meeting, another veteran reported more nightmares and sleep disturbance.) A treatment strategy is therefore required that reflects an understanding of the development of this complex, mutually interacting system of dysfunction.

The design of intensive inpatient treatment programs for Vietnam combat veterans is still only a decade old. The field is marked by an atmosphere of enthusiasm and experimentation which has led to both ambitious programming and lack of clarity. For example, these comprehensive programs often combine a number of conflicting methods such as abreactive, suppressive, bolstering, confrontative, and re-framing techniques (Adams, 1982; Arnold, 1985; Berman *et al.*, 1982; Rosenheck, 1984; Sax, 1985; Scurfield, 1985; Schwartz and Doherty 1987; Silver, 1986; Starkey and Ashlock, 1986). Many issues have been raised with little consensus, including (1) when is inpatient treatment preferable to community-based outpatient treatment? (2) What is the optimal length of stay? (3) Which emphasis is more effective: stabilization and respite, or abreaction and indepth exploration? (4) Should veterans be

treated in cohorts or rolling admissions? (5) How much emphasis should be placed on Vietnam vs. current life problems? (6) Should PTSD be treated as an acute or chronic condition? (Atkinson *et al.,* 1985; Atkinson *et al.,* 1988; Baringer *et al.,* 1990; Smith, 1986). It has become increasingly clear that a model of intervention based on recovery from acute trauma is no longer appropriate for Vietnam veterans, and that at least for some veterans abreaction may increase their symptomatic distress. Indeed, data from treatment studies with chronic mental illness (Paul and Lentz, 1977), substance abuse (Boudewyns *et al,* 1991; Miller and Heather, 1986; Schnitt and Nocks, 1984), and cardiac illness (Levine *et al.,* 1987) clearly indicate that exploratory, abreactive, emotionally arousing treatments may be counterproductive for people struggling with chronic conditions. We may find this to be true for chronic PTSD as well. Though a number of empirical studies of flooding have found positive results, the authors uniformly emphasize the importance of rigorous screening criteria (Boudewyns *et al.,* 1990; Keane *et al.,* 1989; Lyons and Keane, 1989; Fairbank and Keane, 1982).

Currently, there is a need to develop sophisticated models of inpatient treatment based on theoretical principles, and not only clinical experience and intuition. Once these models are developed, treatment outcomes studies can be designed to provide the data needed to answer the questions listed above. Comparison across treatments and studies will be aided by clear models. Conceptualizations of treatment strategy have been clearer for individual techniques such as implosive therapy (Lyons and Keane, 1989). In this paper, we will attempt to offer one such conceptualization for comprehensive inpatient PTSD treatment. At the heart of our model is the notion that these veterans have experienced a pervasive developmental crisis in late adolescence that has interfered with their individuation as mature adults, crippling their adaptation to the world. The fundamental causes of this crisis are alterations in cognitive processing, regulation of affect, and representations of self and other occasioned by overwhelming trauma. Treatment is conceptualized as a two-phase process that attempts to redress these developmental problems. First Generation programs focus on accessing and then working through the effects of the war trauma and aim to diminish the intensity of core PTSD symptoms. Second Generation programs focus on reintegrating veterans into the social context of family and work, and aim to improve their ability to function in society. They are a natural outgrowth of First Generation Programs. Both types of treatment may be required in order to help veterans resume their psychological and social development. First we will present a theoretical framework underlying this distinction and then describe the essential characteristics of First and Second Generation programs, including examples of specific treatment methods.

Though the focus of this paper is on Vietnam veterans with PTSD, it is likely that the issues raised here will be relevant to the inpatient treatment of other traumatized populations, particularly those with significant potential for developing into chronic conditions.

A DEVELOPMENTAL THEORETICAL FRAMEWORK

We propose that currently the primary aim of treatment for Vietnam veterans with PTSD is to improve their level of adaptation to their environment. We will examine adaptation from a developmental point of view, consistent with the work of other authors (Fish-Murray *et al.,* 1987; Green *et al.,* 1985; Horowitz, 1976), though we acknowledge that this perspective cannot capture all aspects of the issues raised by PTSD. We will primarily utilize the ideas of Piaget (1962), who analyzes adaptation in terms of two constituent processes: *accommodation*, in which the individual modifies established schemas (motoric, symbolic, and cognitive) in response to environmental stimuli and objects, and *assimilation*, in which the individual incorporates external objects, symbols, or ideas into previously learned schemas. Accommodation leads to learning new schemas, while assimilation leads to new uses of objects. Accommodation represents the primacy of the external world over the internal, and is accomplished largely through imitation. Work is an adult activity that emphasizes accommodation by the person to the demands of the roles and tasks established by the organization. Assimilation on the other hand represents the primacy of the internal world over the external, and is accomplished largely through play and fantasy. Imagination and creativity are adult activities that rely on assimilation.

Successful adaptation occurs when these two processes are relatively balanced, providing what Piaget identifies as "mobility and reversibility of thought." The balanced interaction between self and environment allows for both to be transformed in ways that provide integration of experience, as, for example, in the development of comprehended language. The elements of language (i.e., letters, words, grammar) are learned through imitation (i.e., accommodation), but are given meaning by linking them to personal association and images (i.e., assimilation). The result is that one person can communicate inner states of feeling and thought to another.

Though Piaget's concepts refer largely to cognitive processes, they are also applicable to an understanding of the regulation of affect. Lane and Schwartz (1987), for example, have proposed a model of affect development based on Piaget's concepts. The development of flexible and complex

cognitive structures allows for processes of symbolization, representation, and mental imagery, all of which are essential to the expression and transformation of states of bodily arousal into experienced emotions. Similarly, while Piaget did not emphasize the interpersonal dimensions of adaptation, Winnicott's (1953) concepts of transitional object and transitional space contribute to an understanding of the optimal interpersonal environment for successful adaptation by the child. The transitional space is the intermediary realm between mother and child in which the boundaries between self and other are merged. This "holding environment" provides a relatively safe opportunity for the child to experiment with both accommodating to the external world and assimilating objects into his/her play. If the mother either does not allow the child room to play, or alternatively is too responsive to the child's every need, then the situation becomes imbalanced, and the safety of the transitional space becomes threatened.

Assimilation and accommodation also become imbalanced when the individual confronts a totally new or incomprehensible situation, as in the case of a traumatic event. In this case, the individual may respond by retreating to previous schemas as a means of resisting the impact of the trauma. Thus, in the midst of the event, people may engage in irrelevant actions such as grooming themselves, singing a childhood song, or calling out for their parents. Another response is the total accommodation or modification of existing schemas in the service of survival, that is, completely giving oneself over to the event (e.g., during combat, giving up notions of oneself as a moral being and becoming a rampaging beast). We propose that the etiological root of what will later emerge as a PTSD may be this act of pure accommodation. At this moment, the person's cognitive processing of experience collapses, and the event is recorded (i.e., internalized) whole within memory in great detail. These unassimilated pieces of traumatic experience may then remain beyond words and cognitive representation. They become split off, and will return later as flashbacks and nightmares. The person's belief systems are also altered as a result of this accommodation, a process Janoff-Bulman (1985) describes as shattered assumptions. The person's ongoing moral development and existential security may also be profoundly challenged.

DEVELOPMENTAL STAGES OF ADAPTATION IN COMBAT TRAUMA

Preparation as a soldier is based on severe accommodation: beginning in boot camp, previously learned schemas are replaced with new ones by the drill sergeant, whose job it is to force accommodation to the demands

of the soldier's role. Experience later in combat also forces immediate accommodation to environmental influence. Assuming these processes are not traumatic, the person can partially assimilate them through a hierarchical categorization of ideas such as "what I need to do as a soldier," "it will be temporary," or "this will make a man out of me." In the case of a traumatic experience during combat, the person's integrative capacity may be short-circuited, and assimilation becomes impossible. The person's previous back-home schemas are then replaced by war-related schemas through forced accommodation, as described above.

For Vietnam veterans, this overemphasis on accommodation did not end when their tour of duty was over. Societies have always found ways of reintegrating their returning soldiers. Ceremonies, parades, benefits, and general support both give them recognition, as well as remind them to give up the soldier role and dampen their aggressive behavior. Eventually, veterans adjust to family and work settings, but are allowed to maintain separate arenas, in place and time, where they are not expected to maintain their accommodation to society. These VFW halls, memorial services, and holidays are sanctioned in the service of their overall adaptation.

In the case of Vietnam veterans, society did not perform this integrative function, largely due to the shame generated by the lack of success of the war effort. Contributory factors include the speed of their return from the field to the United States, the fact they came home as singletons, and the conflictual political environment they encountered. The fact that they had changed was not acknowledged, and so they were expected to accommodate immediately to society. The result was that many could not accommodate to civilian life. Those who were able to accommodate did so only by compartmentalizing their Vietnam identities and experiences. Traumatic schemas remained unaltered. As a number of authors have noted (Catherall, 1989; Figley and Leventman, 1980; Lipkin *et al.*, 1982), this secondary traumatization probably contributed to the severity of PTSD in these veterans.

For those who later developed PTSD, the sequelae of trauma has continued over the course of their adult development (Levinson, 1978). Paradoxically, their alienation from society may have served to cut off their dependent ties to their families, and may have precociously advanced their sense of independence. During their twenties, many appear to have become either *transients*, who moved from job to job, and relationship to relationship, or what Levinson terms *locked in*, by quickly attaching themselves to a caretaking woman, beginning a family, and staying at one job. The degree of their maladaptation may have been less visible during their twenties because society's expectations of men at this age were less discrepant with their behavior. However, as these veterans moved into their thirties, which

Levinson calls the Settling Down period, many of their work and relationship problems created much more distress. This phase of development requires substantial accommodation to a life structure, a task many were unable to perform. Currently, most Vietnam veterans are in the mid-life transition. The developmental task of this phase is one of life review and setting a new course, a task that closely matches that of psychotherapy and treatment. If this process of review, supported by treatment, is successful, then a phase of renewal may begin for these veterans. If not, resignation and defeat are likely outcomes. PTSD inpatient treatment offers these veterans in their midlife transition an opportunity to achieve that adaptation to society they have missed or avoided.

EFFECTS OF TRAUMA ON THE VETERAN

We hypothesize that the forced accommodation to a traumatic stimulus and then to an unreceptive society significantly affects Vietnam veterans with PTSD in at least four domains: (1) relationships to society's norms and expectations, (2) relationships with other people, (3) cognitive processing, and (4) ability to symbolize affect states. Let us review each of these areas.

First, it creates an impairment in accommodation to the world. Largely supported by processes of avoidance and isolation, these veterans feel that no one understands them, feel shame for being Vietnam veterans, do not talk about their experiences, and avoid contact with other veterans. They cannot accommodate to the demands of their employers, spouses or family, treatment settings, or societal rules. This leads to being fired, divorced, or jailed. Further alienated from society, they turn to their war experiences to find solace and a stable self-representation. Therefore, their lives become increasingly bifurcated into pre-Vietnam and post-Vietnam selves.

Second, their impairment in accommodating to external objects prevents them from establishing mature identifications. Since the trauma occurred at an age when identity integration was of paramount importance, significant deficits are often created. The loss of a sense of group, as well as lack of identification with the leader, undermines identification with authority figures, parents, and mentors after they returned. Ineffective attempts at identification might include: pseudo-mutual bonding by expressing highly fused identifications as "brothers" who are "one," which covers highly charged suspicions about each other and feelings of complete isolation (Brende, 1983; Frick and Bogart, 1982; Parson, 1984; van der Kolk, 1987); identification with the aggressor by imitating the dress and

life style of the hippies who were perceived to have denigrated the veterans when they returned; and reliance on external signs of identity by wearing a multitude of buttons, pins, hats and tattoos. These insignia may express both the profound fragmentation of a shattered self-image and the wish to make it whole again.

Third, these veterans with PTSD are unable to modify their cognitive schemas which are now rooted in the war experience. For example, ideas that they need a weapon, that they are holding the dead spirits of buddies, that other people cannot understand them, that they are in danger, or that they were murderers, remain robust. New experiences with their families or employers continue to be assimilated into these schemas, though others view them as misperceptions of reality. The loss of mobility of thought that Piaget describes is evident in the highly compartmentalized thinking of veterans with PTSD. When challenged, they may demonstrate paranoid, phobic, or obsessive behaviors, all of which are fueled by the need to stay in control and ward off the intrusion of discrepant associations. Compulsive rituals interfere with normal family functioning; mistaken perceptions lead to poor judgments and decision-making.

Fourth, significant impairment exists in their capacity to symbolize and to translate feeling states into meaningful language. This may also be a result of the imbalance between assimilation and accommodation, in which the traumatic material and other ideas that come to be associated with it remain split off. This state of alexithymia (Krystal, 1979; Krystal *et al.*, 1986) cripples their ability to access memories, express feelings, and deal with emotionally arousing situations. Unprocessed affects of trauma cause them to ward off arousal through anger, substance abuse, and flight.

The lack of ability to symbolize their experience may also cause a loss of meaning. Meaning is generated by the association of two separate areas of experience, in this case the war and previously-held self representations. When this association is blocked, meaning falls victim. Therefore, the war comes to have no meaning, because veterans can only call up war related schemas in what becomes a self-referential cycle. Figure 1 summarizes these causes and effects.

TREATMENT MODELS

During the 1970s, veterans approaching medical centers were expected to accommodate to existing programs, diagnoses (e.g., anxiety, psychosis, depression), and standards. Too many times they were not even asked whether they had seen combat. Treatment usually involved suppression

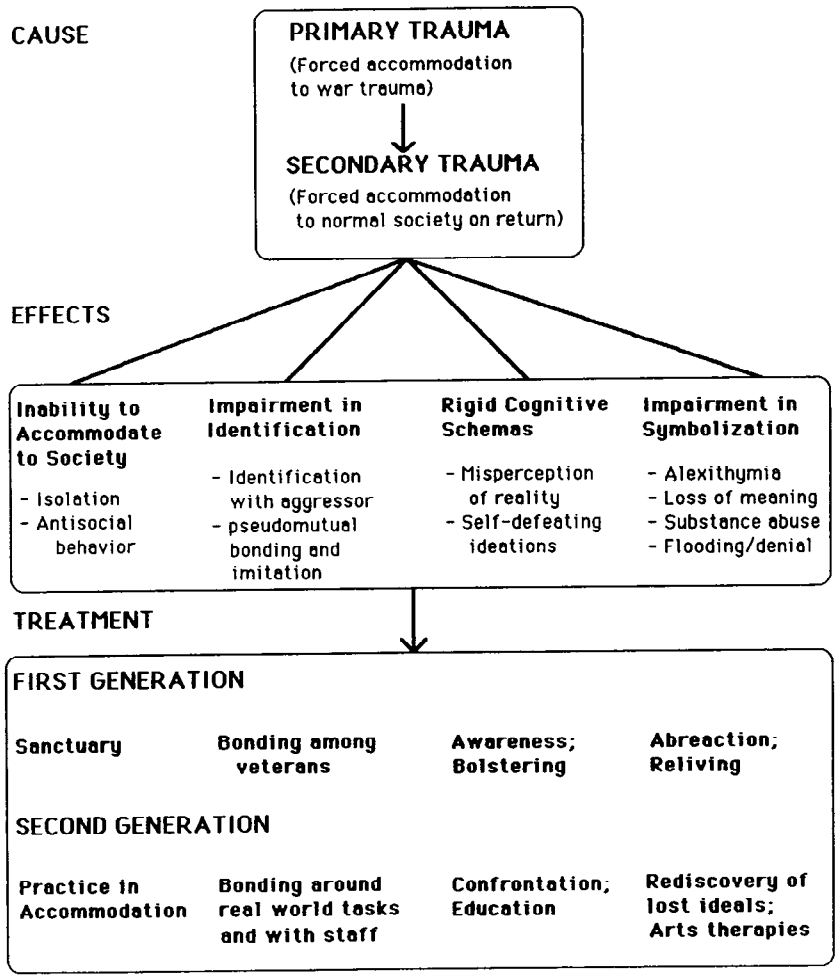

Fig. 1. First and Second Generation Treatments for PTSD.

of symptoms and short-term stabilization. In this preliminary phase, treatment matched the general response of society. Even when exploratory treatment was provided, the impact of combat trauma was avoided by the emphasis placed on childhood experiences by then current theoretical models of neurotic symptoms and character pathology.

By 1980, the beginnings of acknowledgment occurred with the emergence of rap groups, the recognition of the diagnosis of PTSD, and the VA's initiation of specialized PTSD programs. This phase, which we will call the First Generation, has been characterized by specialized treatment for Vietnam veterans that focuses on the review of war experiences, bonding among them in groups, and attempts at abreactive treatments, from either behavioral or psychodynamic perspectives (Boudewyns *et al.*, 1990; Parson, 1984).

First Generation programs aim to provide a corrective emotional experience for Vietnam veterans, by being highly responsive to their needs, recognizing their entitlement to services previously not given, and by welcoming them back home with respect. These programs emphasize a review of the war, particularly the primary traumas, and management of the core PTSD symptoms of re-experiencing, avoidance, and hyperarousal (Gusman, 1990; Scurfield, 1985; Silver, 1986). The optimal environment for First Generation work occurs when the treatment setting is experienced as a sanctuary in which their special needs are attended to, and they are given a great deal of support. The primary task of the therapist is listening to their story. Hope is generated by the idea that if you can "get it out," your load will be lightened, and your recovery can begin. To facilitate this process, homogeneous groups of combat veterans (among both patients and staff) provide the most trusting atmosphere. The idea that "no one can understand me," is replaced by "we, as Vietnam veterans, can understand you." The world, by becoming responsive, can now be assimilated by the veterans.

THE MODEL FOR A SECOND GENERATION PROGRAM

First Generation programs are probably essential to the initial treatment of veterans suffering from PTSD. Ideally they would have been available twenty years ago. However, once veterans have understood that they are not alone, and have reviewed their combat experiences, then the second step needs to occur in the normative process of adaptation: reintegrating into society. It is this task that defines the purpose of Second Generation programs.

> Traumatized persons need to abandon their identity of being a victim. This requires active reexposure and attention to other people's lives, interests, and difficulties. . . It is crucial to avoid the formation of a group of victims united against a dangerous world, with an idealized leader who will protect the members against further harm. (van der Kolk, 1987, p. 165)

It is for this reason that shifting from homogeneous to heterogeneous groups of trauma victims has been consistently recommended (Herman and Shatzow, 1984; Parson, 1984; van der Kolk, 1987). If early treatments of Vietnam veterans overemphasized accommodation, and first generation programs emphasize assimilation, then Second Generation programs attempt to reestablish a balance between accommodation and assimilation. Table I summarizes the principal differences between First and Second Generation programs.

Second Generation programs tend to focus on the secondary trauma, the present and future rather than the past, on involvement with family and community rather than fellow veterans, and on relationships outside of the Vietnam/trauma circle.

It is our impression that though many currently existing programs were created along first generation lines, they have shifted their emphasis toward second generation principles. This shift, which has been a natural response to the shift in needs of the veterans, has largely been implicit and unexamined. This paper attempts to make these differences explicit. Let us review how second generation programs might address the four main effects of trauma (see Figure 1).

Inability to Accommodate to Society

Second generation programs provide veterans with opportunities to practice accommodating to societal expectations, through graduated exposure to the community. Treatment therefore occurs in the context of an open system, in which boundaries are permeable. Second Generation programs will tend not to be homogeneous, self-contained sanctuaries set off from "others." They will tend not to restrict patients to the ward and instead encourage or require overnight and weekend passes home with family or friends. The ward will include non-Vietnam veterans, so that inter-veteran relationships can be addressed. The staff will not be primarily Vietnam veterans, but instead will be representatives of the world, helping the patients to interact with them. To the veterans' concerns that the staff cannot understand them because they were not there, the staff respond, "We are not experts on Vietnam, but we are not in Vietnam. We are part of the World, and the World is what you have to learn about." In addition to small group work, family therapy and education will be emphasized. Instead of wilderness adventures or helicopter rides, adventures into the community will be sponsored (such as volunteering, speaking in high schools, and recreational events in public settings). Finally, adherence to the rules of the unit, hospital, and community are focused upon, not merely in the service

of maintaining control, but in order to identify difficulties in accommodation and to examine the issues (e.g., resentment, authority, misperceptions) underlying them.

Second generation programs do not suppress acknowledgment of traumatic memories, but instead may use ceremonies and rituals in order to compartmentalize the processing of traumatic memories and schemas. Special ceremonies honoring the dead, welcoming the veterans home, or making the transition back to their families help to consciously recognize Vietnam-related materials, but in the service of setting it aside so that life can go on.

Finally, PTSD symptoms are redefined or translated into the language of current life challenges rather than into the language of war. For example, nightmares are defined as events that disturb marital relationships, startle as an event that causes embarrassment, avoidance symptoms as hindrances to family life, and anxiety as a trigger for substance abuse. Discussion of these symptoms leads to facing current life problems, not their roots in Vietnam.

Impairment in Identification

Second generation programs attempt to foster mature identifications among the veterans. Unhelpful modes of identification are interfered with: for example, by addressing differences among the veterans rather than similarities, restricting the use of Vietnam hats, pins, and insignia, and confronting pseudomutual bonding among the veterans. Positive identifications are encouraged, through strong staff leadership, encouragement for veterans to identify closely with staff, and involvement in engaging group programs based on real world tasks such as community projects, volunteer work, team sports, and creative performances. Finally, obstacles to identification within normative family structures are removed, such as through attention to men's issues (Rosenheck, 1985), and training in parenting skills and marriage counseling. The veterans are placed in the role of teacher to their families, educating them about how the war experience interferes with their reality-testing and interactional capacity. The purpose is to stimulate empathy in family members, and distance the veterans from the past. From "only Vietnam veterans can understand me," the veterans move to "I can successfully communicate my experience to other people."

Table I. Summary of Differences Between First and Second Generation Programs

Element		First Generation	Second Generation
1.	Psychological principle	Assimilation	Accommodation and Assimilation
2.	Metaphor for treatment	Purging	Carrying a burden
		Coming out of woods	Coming home
		Sanctuary	School
3.	Major Focus	Primary Trauma	Secondary Trauma
		Review of war experience	Review of current events
		Focus on past	Focus on present/future
4.	Methods	Abreaction/reliving	Education/memorializing
		Outward bound	Passes home to family
		Protected environment	Community involvement
5.	Group Process	Homogeneous	Heterogeneous
		Address similarities	Address differences
		Encourage strong bonding	Address pseudomutuality of bonding/encourage strong family bonding

Rigid Cognitive Schemas

Second generation programs attempt to educate veterans about the unhelpful ideas they have developed that keep them separate from others. Rigid notions are assertively confronted, sometimes with humor, in order to put the veterans into a questioning mode. Rigid ideas include (1) that they are hopeless and no one can understand them, (2) they need a weapon near them at all times, (3) their anger is always justified, (4) substance abuse is just self-medication, (5) anxiety is intolerable, (6) they can't go with their lives until they receive an apology, (7) they are keeping the spirits of their dead buddies alive, or (8) flashbacks and nightmares cannot be controlled. The emphasis is less on providing definite facts about PTSD than on making them question their rigid thinking, to realize that every veteran had a different experience, that each human being has a legitimate perspective, and therefore that they need to learn how to listen to others, particularly their families. Listening, checking out perceptions, and getting feedback are the essential skills requiring constant practice.

Impairment in Symbolization

Second Generation programs do not rely on abreaction or retelling as means of helping veterans resymbolize their experience. These methods have been used in First Generation programs with some benefit (Boudewyns *et al.*, 1990). The aim instead is to help them learn how to transform their feelings and inner states into images and then words that communicate meaningfully to others. The treatment of alexithymia may have significant impact on their interpersonal relationships, sense of well-being and competence, and capacity to delay discharge of impulses. The creative arts therapies (art, drama, music, poetry) may be especially helpful methods since they involve expression in imagistic, symbolic, and nonlexical modalities, intermediate between kinesthetic arousal and verbalization (Golub, 1985; Johnson, 1987). This transitional space in which veterans can play with and yet still partially disown their own feelings, provides an opportunity to symbolize and sublimate their traumatic experience into effective communications. Raw and diffuse states of arousal can be transformed into cognitive representations. The public presentation of these products through art shows, theatrical plays, poetry readings, or musical concerts is an important component in this process. Inner confusion becomes creatively represented and then publicly appreciated; in this way, the veterans discover understanding and acceptance from "the world" (Emunah and Johnson, 1983).

The loss of meaning is the result of the constant mapping of current experience onto traumatic schemas. The forceful reminder of previous schemas and ideals that they held before the war, as well as development of new schemas (e.g., living for one's children), allows them to regain some degree of meaning. The unearthing of a continuity in development from before the war, through the war, and after the war, provides a profoundly reassuring context or ground on which the redefinition of self can begin again (Gusman, 1990). Second generation programs encourage the veterans to go beyond this insight and practice re-engaging in activities that had given them or might now give them meaning (e.g., rediscovering old hobbies, volunteering, taking a college course, vocational training, teaching).

DEMORALIZATION AND HOPE

The developmental approach reaches its limits with the issue of meaning and discovering a reason to live. Existential and moral perspectives are also required (Frankl, 1969; Vandenberg, 1991). As veterans come to understand the immutability of the Vietnam war, the country's reaction, the traumas, and their behaviors over the past twenty years, they confront the fact that their suffering will continue. Deep reactions of shame and hopelessness may emerge that must be addressed (Brende and Parson, 1985; Titchener, 1986). PTSD has overcome them: what began as a relatively circumscribed disorder has affected their whole life.

Acceptance that one has a chronic condition, and yet that one can go in life by transcending this situation is an important notion of Second Generation programs. First Generation programs, because of their focus on the more acute phase of trauma recovery, are more likely to base hope on metaphors of purging or "getting at" the problem. In Second Generation metaphors, meaning emerges not from a renunciation or overcoming of the traumatic experience, but from an acknowledgment that it serves as a unique part of one's life story. It is the burden that one carries as one goes on with one's life, and which, if carried well, can be a source of strength. Unfortunately, due to the need for integration of a fragmented identity, as well as needs for financial compensation for having the disorder, Vietnam veterans may enthusiastically embrace the diagnosis as the explanation for many aspects of life. This is a powerful dynamic, and even staff of these programs find PTSD can become a metaphor for their lives. Helpful strategies include having other programs or patients with other diagnoses on the unit; working hard not to become insulated from other units in the hospital, the community, or families; and not allowing everything to be attributed to PTSD. The veterans themselves must engage in the same struggle to

reclaim territory taken by the illness. The turning point comes with the realization that while the basic disorder of PTSD cannot be cured, other aspects of life are within their control to change. The capacity to give meaning, to relate to other people, to be sober, and to work, love, and play, can in large part be freed from the grasp of the disorder. Hope is generated by this shift in perception of the illness.

CONCLUSION

This paper has attempted to provide a developmental theoretical framework for inpatient PTSD treatment. While no actual program could be a pure First or Second Generation program, we believe that existing programs and treatment elements within programs can be distinguished along the lines we have presented.

It is essential that clearer conceptualizations of treatment models and basic principles be made, so that scholarly discourse and research regarding them can be enhanced. No treatment outcome study has yet examined inpatient PTSD programs from this perspective (Boudewyns *et al.,* 1990; Harmand *et al.,* 1987; Perconte, 1989; Scurfield *et al.,* 1990).

We cannot continue to provide First Generation programs to Vietnam veterans as if the primary traumas are the only focus of treatment, or as if they have recently experienced them. These veterans are now in their forties and are facing their chronic illness in the context of the normative developmental challenges of mid-life. It is time that these veterans come home from the war, and transform their suffering into active participation in today's society. Specialized inpatient PTSD units should be crucibles of this transformation, in which these persons can be re-integrated back into society in a dynamic way. Beyond sanctuaries, they need to be gates of entry from Vietnam to America, and from the traumatic to the everyday.

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